

Patient-Centered Medical Home: What Is It and How Do SBHCs Fit In?

Sue Sirlin, CPEHR

Director, HIT Consulting Services

Bonni Brownlee, MHA CPHQ CPEHR

Principal Consultant

March 15, 2013



Advancing Healthcare
Improving Health

Goals for Today's Session

- Understand history and development of the PCMH model
- Understand how PCMH concepts provide enhanced patient care
- Review the accrediting bodies for PCMH
- Learn what's happening with SBHC's and PCMH on a national level



History and Development of the PCMH



PCMH History

- **1967:** Concept introduced by AAP.
- **1978:** WHO established the basic tenets of the PCMH and the importance of primary care.
- **1990s:** HRSA launched National Health Disparities Collaboratives using Chronic Care Model.
- **2001:** IOM publishes “Crossing the Quality Chasm”: A New Health System for the 21st Century.
- **2004:** PCMH model promoted by AAFP and MacColl Institute.
- **2007:** “Joint Principles of the Patient-Centered Medical Home” published in collaboration by the AAP, AAFP, APC, and AOA.
- **Today:** All states piloting PCMH models for achievement of operational excellence, improvements in patient care, patient experience, and clinical outcomes.



PCMH Today

- Has begun to capture the attention of Federal and State Government, employers and health plans.
- Since 2007, sets of PCMH standards have been developed by accreditation agencies and others:
 - National Committee for Quality Assurance (NCQA)
 - The Joint Commission Patient Centered Medical Home
 - Accreditation Association for Ambulatory Health Care (AAAHC)
 - URAC Patient Centered Health Care Home
 - Multiple states have developed their own standards of performance



American Academy of Pediatrics Perspective on PCMH

- AAP introduced the PCMH model, and continues to be one of its primary advocates.
- AAP states that the medical home model delivers care that is **“accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”**
- The Medical Home assures that children and youth, especially those with special health care needs, have all of the medical and non-medical needs met.
- www.medicalhomeinfo.org



Enhanced Patient Care through the Joint Principles of the PCMH



The Joint Principles of the PCMH

- Personal provider
- Provider directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment



Personal Provider

Each patient has a continuous relationship with a personal clinician trained to provide first contact, continuous and comprehensive care.

- Assignment of PCP
- Empanelment
- Panel management



Clinician Directed Medical Practice

The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- Team-based care
- Cross-training
- Proper staffing
- Working at the peak of skill level and licensure



Whole Person Orientation

The personal clinician takes responsibility for providing for all the patient's health care needs, including coordinating care with other qualified professionals.



This includes care
at all stages of life—

- acute care
- chronic care
- preventive services
- end of life care



Coordination/Integration of Care

Care is coordinated and/or integrated across all elements of the health care system and the patient's community.

- Care is facilitated by registries, information technology, health information exchange, and other means.
- Health care organizations strive for integrated care.
 - Medical, dental, behavioral health



Quality and Safety

Quality and Safety are hallmarks of the medical home.

- Planned care
- Evidence-based medicine
- Clinical decision-support tools
- Clinicians and care teams engaged in QI efforts
- Value patient's experience
- Use of HIT to support patient care, performance measurement, patient education, and enhanced communication



Access to Care

Enhanced access to care is available.

- Open scheduling
- Expanded hours
- Communication options between patients, physicians, and care teams



Payment

Payment appropriately recognizes the added value provided to patients who have a medical home.

- Non-personal encounters
- Coordination of care
- Adoption and use of HIT
- Enhanced communications
- Incentives to physicians for reduced hospitalizations and ER visits
- Incentives for achieving quality benchmarks



Where to Start? Change Concepts for Practice Transformation



PCMH Transformation Framework



1. Laying the Foundation

Engaged Leadership

Quality
Improvement Strategy

- Key feature is leadership that can: envision a future, facilitate staff involvement, and devote time and resources to make changes.
- Practices that succeed in quality improvement initiatives have *adaptive reserve* – the ability to learn and change.
- Leaders support continuous learning throughout the organization. They review and act on data.
- Practices that don't routinely measure and review performance are unlikely to improve.



2. Building Relationships

Empanelment

Continuous,
Team-Based Relationships

- Empanelment is *the* platform for population health:
 - Links patients to care teams
 - Continuity of care yields better health outcomes
 - Profoundly changes culture and sense of accountability
- Team involvement in the care of the chronically ill is the single most powerful intervention:
 - Providers must be trained and given protected time to lead the team.
 - New relationships and new communication strategies have to be established.



3. Changing Care Delivery

Patient-Centered Interactions

Organized,
Evidence-Based Care

- Patient activation is tied to health improvement.
- Patient involvement in QI activities and health center boards helps maintain the focus on patient and family needs.
- Well-organized care is patient-centered care.
- Well-organized care is good care:
 - Practices that do pre-visit planning (huddle) have higher achievement on metrics of chronic disease and preventive care.



4. Reducing Barriers to Care

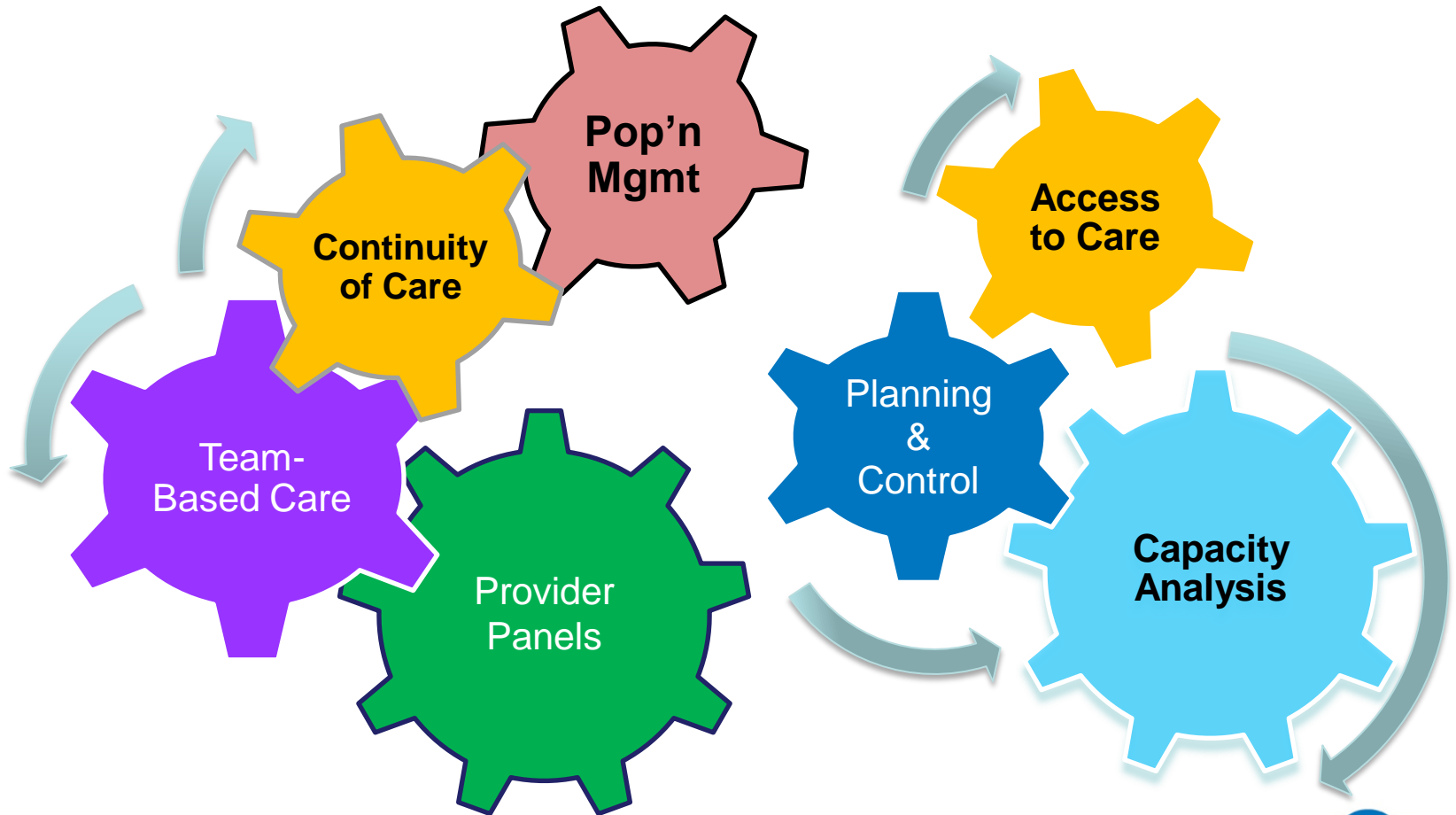
Enhanced Access

Care Coordination

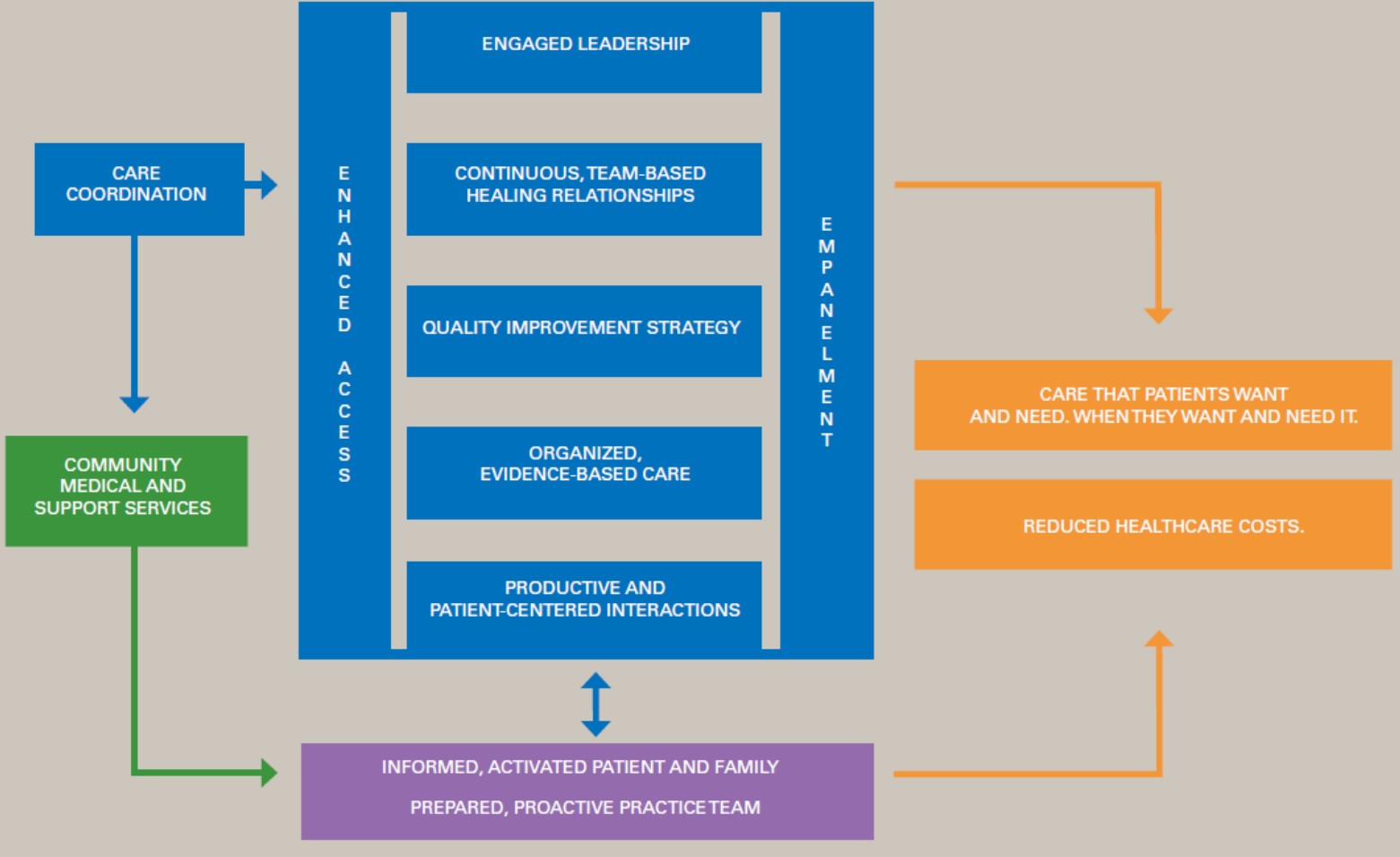
- Care coordination requirements assignment of key activities which are embedded in daily work.
- Continuous access to care teams engenders trust.
- Evidence of cost savings comes, primarily, from improvements in care coordination and access.
- Even a *few* hours of off-hours appointment access is associated with reduced ED use.



The PCMH Model Promotes Access to Care



PATIENT-CENTERED MEDICAL HOME MODEL



The Value of the PCMH

- Demonstration Projects
 - Reduced hospitalization rates 6-19%
 - Reduced ER visits 0-29%
 - Increased savings per patient \$71-\$640 (Source: Fields, et al. 2010)
- Other Benefits
 - Less staff burnout (10% in PCMH practices compared to 30% in controls)
 - Reduced cost of care (29% fewer ER visits, 6% fewer hospitalizations, estimated saving of \$10.30/patient/month)
 - Improved patient experience
 - Improved HEDIS scores

(Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP, Trescott CE, Erikson M, Larson EB. The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Provider Health Affairs 29:5 (2010): 835-843)



Formal PCMH Accreditation



Why Attain Formal PCMH Accreditation?

- Drives improvement in patient care and strengthens the operating framework
- Alignment with Meaningful Use
- Market advantage
- Pride
- Potential for increased reimbursement and other incentives



Types of PCMH Accreditation



Comparison of PCMH Surveys

Content Area	AAHC	The Joint Commission	NCQA	URAC
Eligibility	Organizations providing health care services in ambulatory settings	Stand-alone primary care practices	Primary care practices, primary care providers (MDs, NPs, PAs)	Legally organized health care practices
Levels of Recognition	3 (best), 2, and 1 yr. distinction	Pass/fail; must first have ambulatory care accreditation	3 based on point system	2 - Practice Achievement and Practice Achievement with EHR

Source: PCDC Crosswalk of Medical Home Standards/Certification



Comparison of PCMH Surveys

Content Area	AAHHC	The Joint Commission	NCQA	URAC
Application Process	Online survey, document submission, on-site review	Online application, scheduled on-site visit, possible additional unscheduled	Online survey	Audited by a certified organization
Recognition Length	1, 2, or 3 year levels of recognition	Up to 3 years	3 years	2 years

Source: PCDC Crosswalk of Medical Home Standards/Certification



Comparison of PCMH Surveys

Content Area	AAHHC	The Joint Commission	NCQA	URAC
Elements	8 core standards and 19 adjunct standards that are appropriate to the services provided by the organization	5 operational characteristics and 12 focus areas in addition to ambulatory care accreditation – all standards must be met	6 standards and 6 must pass elements which must score at 50% or higher	28 standards – 7 of which are mandatory and must be at least partially met as well as selected essential standards

Source: PCDC Crosswalk of Medical Home Standards/Certification



2011 NCQA Recognition Content

1. Enhance Access and Continuity

- **Access During Office Hours***
- After-Hours Access
- Electronic Access
- Continuity
- Medical Home Responsibilities
- Culturally and Linguistically Appropriate Services
- Practice Team

2. Identify and Manage Patient Populations

- Patient Information
- Clinical Data
- Comprehensive Health Assessment
- **Use Data for Population Management***

3. Plan and Manage Care

- Implement Evidence Based Guidelines
- Identify High-Risk Patients
- **Care Management***
- Medication Management
- Use Electronic Prescribing

4. Provide Self-Care Support and Community Resources

- **Support Self-Care Process***
- Provide Referrals to Community Resources

5. Track and Coordinate Care

- Test Tracking and Follow-Up
- **Referral Tracking and Follow-Up***
- Coordinate With Facilities and Manage Care Transitions

6. Measure and Improve Performance

- Measure Performance
- Measure Patient/Family Experience
- **Implement Continuous Quality Improvement***
- Demonstrate Continuous Quality Improvement
- Report Performance
- Report Data Externally
- Use Certified EHR Technology

***Must Pass Element**



How do School-Based Health Centers fit in?



National Assembly on School-Based Health Care

- “SBHCs enhance **access** to **high quality** primary care by situating services in the most accessible location for young people: their schools.”
- “Because of their proximity and routine access to children and adolescents, SBHCs serve as the first (and sometimes only) contact or access point for **continuous and comprehensive** care for young people with complex medical, behavioral and social needs.”
- “SBHCs utilize an interdisciplinary team approach to deliver **coordinated** primary care across physical, behavioral, emotional and social dimensions of health – and within the context of family and community, as appropriate.”



Can a SBHC be a PCMH? – Group Discussion

The Joint Principles of the PCMH:

- Personal provider
- Provider directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment



Findings from Interviews with FQHCs

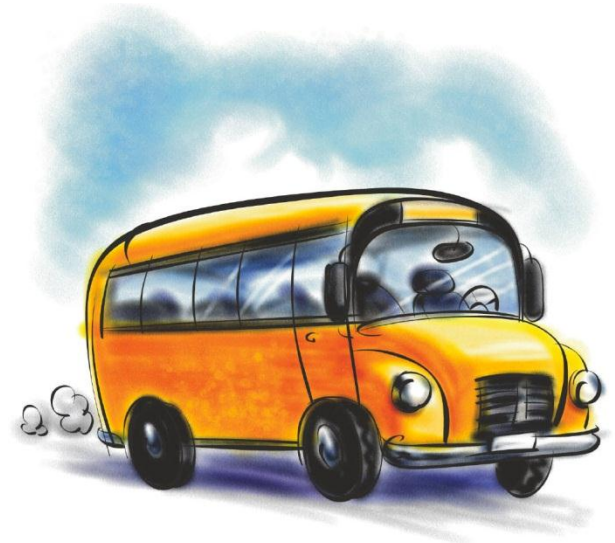
- Most FQHCs pursuing NCQA PCMH recognition
- SBHC included in most PCMH plans
- Challenges reported include:
 - 24/7 access-full year and after hours
 - Technology – some SBHC's lagging in EHR implementation
 - Providers are not PCPs
 - Quality improvement activities do not include SBHC representation



Can a SBHC be a PCMH?

It depends...

- SBHC models vary...
 - Clinic Structure varies:
 - FQHC
 - Satellite vs. Licensed Clinic Location
 - School-District Run
 - Provider Teams vary:
 - Part time, Rotating
 - MD, Mid-Levels
 - Clinic Role varies:
 - Students Only vs. Community Members



Can a SBHC be a PCMH?

To meet the intent of the PCMH Model:

- SBHC model needs to include:
 - Primary medical care
 - Open year round
 - Stable medical providers for continuity
 - Ability to see family members of students
 - Liaison to community health partners for:
 - After hours care
 - Specialty referrals
 - Immunization registry



SBHCs are natural primary care extenders

- Community access points
- Immunizations
- Oral health screenings
- Sensitive teen services
- Acute / urgent care
- Behavioral health
- Risk assessments
- Health education
- Family support



Questions



Sue Sirlin, CPEHR

ssirlin@outlook-associates.com

Bonni Brownlee, MPH CPHQ CPEHR

bbrownlee@outlook-associates.com



Advancing Healthcare
Improving Health